B E N E F I T D E S C R I P T I O N

(Herein called "Description")

HEALTH CARE PROGRAM FOR:

GROUP NAME: Kansas State Employees Health Care Commission
(Kansas Choice Benefits)

This booklet describes the health benefits that

KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION

provides to its eligible Members and their Dependents. These benefits are underwritten by

KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION

Blue Cross and Blue Shield of Kansas, Inc., has been retained to administer claims under this Program. Blue Cross and Blue Shield of Kansas, Inc. is not the insurer under this Program. Blue Cross and Blue Shield of Kansas, Inc. provides administrative claims payment services and does not assume any financial risk or obligation with respect to claims. For answers to questions regarding claims payments, eligibility for benefits, and other information about this Program, contact Blue Cross and Blue Shield of Kansas, Inc., 1133 Topeka Boulevard, Topeka, Kansas 66629.

Administered by Blue Cross and Blue Shield of Kansas

TABLE OF CONTENTS

PART I DEFINITIONS ..... Page 3

PART II KANSAS CHOICE BENEFITS SCHEDULE ..... Page 8

"KANSAS CHOICE" PROGRAM ..... Page 12

OUTPATIENT SERVICES FOR NERVOUS OR MENTAL CONDITIONS ..... Page 19

PART III GENERAL EXCLUSIONS ..... Page 21

PART IV ALLOWABLE CHARGES AND PAYMENT OF CLAIMS ..... Page 24

PART V COORDINATION OF THIS BENEFIT DESCRIPTION'S BENEFITS WITH OTHER BENEFITS Page 27

PART VI ENROLLMENT AND BEGINNING OF COVERAGE ..... Page 30

PART VII TERMINATION OF ELIGIBILITY ..... Page 31

PART VIII CONTINUED GROUP BENEFITS AND CONVERSION ..... Page 32

PART IX GENERAL INFORMATION ..... Page 33

NOTE: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

PART I

DEFINITIONS

A. **Accidental Injury** means an injury to Your body caused solely through external, violent and accidental means. "Accidental Injury" does **not** include hernia; injuries to the natural teeth caused by an accident; disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound).

B. **Allowable Charge** means the amount that Blue Cross and Blue Shield of Kansas determines to be the maximum amount for service(s) provided. The Allowable Charge and Payment of Claims sections provide additional information concerning Allowable Charges.

C. **Alternate Recipient** means any child of a Member who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Benefit Description.

D. **Benefit Date** means the effective date of the coverage provided by the Underwriter of this Program.

E. **Benefit Description** means a summary of the provisions of the coverage provided by the Underwriter of this Program that affect Members.

F. **Benefit Period** means the time period that begins at 12:01 on January 1 and ends at midnight on December 31 yearly.

G. **Biologically Based Mental Illness** means the following:

1. Schizophrenia, schizo affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;
2. Major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders;
3. Obsessive compulsive disorder;
4. Panic disorder;
5. Pervasive developmental disorder, including autism;
6. Attention deficit disorder and attention deficit hyperactive disorder.

H. **Blue Choice Provider** means an Institutional Provider or Professional Provider of health care services that has entered into an agreement with the Plan under which it is classified as a Blue Choice Provider.

I. **Blue Cross Company and/or Blue Shield Company** means Blue Cross and Blue Shield of Kansas and any other corporation approved or licensed by the Blue Cross and Blue Shield Association to use the registered service marks and names.

J. **Blue Plan Preferred Provider** means an Eligible Provider that has entered into an agreement with a Blue Cross and/or Blue Shield Plan (other than Blue Cross and Blue Shield of Kansas) under which additional Deductibles and/or Coinsurances for use of a non-preferred provider do not apply to such Eligible Provider.

K. **Case Management** means a process conducted by the Company which:

1. Identifies cases involving a Member which present either the potential for catastrophic claims or a utilization pattern that exceeds the norms and demonstrates or has the potential for atypical utilization of services;
2. Assesses such for the appropriateness of the level of patient care and the setting in which it is received;
3. Reviews services requested by the provider for potential alternative use of benefits or coordination of existing benefits; and,
4. Evaluates and monitors the requested services for cost efficient use of benefits.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the Member would otherwise be entitled under the terms of this Benefit Description.

If Blue Cross and Blue Shield of Kansas elects to provide benefits for a Member in one case, it shall not obligate Blue Cross and Blue Shield of Kansas to provide the same or similar benefits for the same or another Member in the same or another case.

Participation in Case Management is voluntary. The Member may withdraw at any time and return to the stated benefit of this Benefit Description.

L. **Coinsurance** means the percentage of the Allowable Charge for a covered service at which payment is made after any applicable Deductible and/or Copay amount has been satisfied.

M. **Company** means Blue Cross and Blue Shield of Kansas.

N. **Company Service Area** means the State of Kansas except Johnson and Wyandotte Counties.

O. **Contracting Provider** means an Eligible Provider who has entered into a Contracting Provider Agreement directly with Blue Cross and Blue Shield of Kansas or through arrangements with another entity.

P. **Convalescent Care, Custodial/Maintenance Care or Rest Cures** means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other care givers who are not Eligible Providers. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.

Q. **Copayment or Copay** means the amount to be paid by a Member before benefits can be provided for a covered service. A Copayment is required each time a specific service such as an office visit is provided. A Copayment does not accumulate toward a specified maximum.

R. **Cosmetic** means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.

S. **Credible Evidence** means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

T. **Deductible** means the amount of Allowable Charges for covered services to be paid by a Member before benefits can be provided for a covered service. Amounts applied toward the Deductible are accumulated until a specified dollar maximum has been reached during a Benefit Period after which no additional Deductible amount is required for the remainder of that Benefit Period.

U. **Dependent** To be eligible to enroll as a Dependent, an individual who is not ineligible by reason of any past disciplinary action initiated by the health plan, must be, at the time of enrollment, one of the following:

Spouse: The Member's legal spouse who is eligible under the Underwriter of this Program's enrollment eligibility rules; or

Child: A natural child, adopted child, step-child, a child supported by the Member pursuant to a valid court order or a child for whom the Member is the legal guardian, and is eligible under the Underwriter of this Program's enrollment eligibility rules. Eligible Dependent children are covered through the end of the month in which they become age 23 unless they have been qualified by the Underwriter of this Program as a handicapped child.

V. **Eligible Provider** means one of the following providers as long as the services provided are within the scope of the licensure of the provider and are covered services according to the provisions of this Benefit Description. Except as otherwise specified, all services must be provided by an Eligible Provider.

1. **Ambulance Service** means any form of transportation which is specially designed, constructed, equipped, and intended to be used for the purpose of transporting sick or injured humans and is operated according to State and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.
2. **Ambulatory Surgical Center** means a facility that meets all of the following criteria: (1) is licensed by the proper licensing agency as an Ambulatory Surgical Center; (2) is not a part of a Hospital; (3) provides hospital-type services for Outpatient surgery.
3. **Doctor or Professional Provider** means a licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery, Oral Surgeon, Podiatrist, Chiropractor, Advanced Registered Nurse Practitioner, Optometrist, Speech-Language Pathologists, Audiologist, registered Physical Therapist, Occupational Therapist or Physician's Assistant.
4. **Freestanding Sleep Center/Laboratory** mean a facility that only performs sleep studies.
5. **Home Health Agency** means a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's place of residence; has policies established by a group of professional personnel which governs the skilled nursing and therapeutic services which it provides; maintains clinical records on all patient's; is licensed according to State and local laws; and is certified by Medicare.
6. **Hospital** means any of the following types of institutions:

   The acute care section of a licensed general Hospital. "Acute care section" means the section(s) of the Hospital in which the average length of stay is 15 days or less; a psychiatric section of a licensed general Hospital; licensed privately operated psychiatric hospitals; and health care institutions operated by the State of Kansas.

   Hospital does **not** include: rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, health resorts, clinics, Doctor's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers or similar facilities.
7. **Institutional Provider** means a Hospital, Medical Care Facility, or Ambulatory Surgical Center.
8. **Medical Care Facility** means a facility that is not a Hospital (see definition of Hospital above) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be: licensed by the State of Kansas to provide diagnosis and/or treatment of a Nervous or Mental Condition.
9. **Other Eligible Providers** means the following providers of Other Covered Services: a Registered Nurse, Licensed Practical Nurse, or supplier of orthopedic and prosthetic devices and of medical equipment.

W. **Except as Limited** is a phrase You will see before explanations of Covered Services. It means that all coverage under this Benefit Description is controlled by the conditions described in this Benefit Description, including Waiting Periods and Exclusions.

X. **Experimental or Investigational** refers to the status of a drug, device or medical treatment or procedure:

1. If the drug, device or medical treatment or procedure cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug, device or medical treatment or procedure is not Research Urgent as defined in these General Definitions; or,
2. If Credible Evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means or treatment or diagnosis and the trials are not Research Urgent as defined in these General Definitions or,
3. If Credible Evidence shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared

with the standard means of treatment or diagnosis and the trials are not Research Urgent as defined in these General Definitions; or

4. If there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis.

Y. **Health Management Strategies International, Inc (HMS)** means the company with which Blue Cross and Blue Shield of Kansas contracts for mental health and substance abuse services.

Z. **High-Dose Chemotherapy** is defined as the dose of chemotherapy which exceeds standard doses of chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells must be implanted or infused to keep the patient alive. Thus, the role of autologous bone marrow transplantation or peripheral stem cell support is not as a treatment, but to restore the bone morrow destroyed by the High-Dose Chemotherapy.

AA. **Hospice** means a legally constituted organization or agency, centrally administered, medically directed, nurse coordinated program providing comprehensive, continuous Outpatient and home-like Inpatient care for terminally ill patients and their families. It systematically joins together employed professionals and trained volunteers to form an interdisciplinary group, to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during the dying and bereavement processes.

BB. **Hospice Care Plan** means a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan will be designed to provide care to meet the special needs during the final stages of a terminal illness.

CC. **Hospice Patient** means a patient diagnosed or referred, or both, to a Hospice as terminally ill by an attending physician, who alone, or in conjunction with designated family members, has voluntarily requested admission into a hospice program or whose guardian has requested admission on behalf of such patient into a hospice program and who has been accepted into a hospice program. Written certification by the patient's Doctor that the Hospice Patient has a life expectancy of 6 months or less is required.

DD. **Hospice Patient's Family** means the Hospice Patient's immediate family, including a spouse, brother, sister, child or parent. Other relation and individuals with significant personal ties to the Hospice Patient may be designated as members of the Hospice Patient's Family by mutual agreement among the Hospice Patient, the relation or individual and the Hospice Team.

EE. **Hospice Team or Interdisciplinary Group** means the attending physician, and the following hospice personnel: physician, licensed professional or licensed practical nurse, licensed social worker, pastoral or other counselor. Providers of special services, such as mental health, pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included on the Interdisciplinary Group as the needs of the patient dictate.

FF. **Identification Card** means a card issued to identify You as a Member of Kansas Choice.

GG. **Inpatient** means a setting in which services are provided to a person who has been admitted to a Hospital or Medical Care Facility.

HH. **Intensive Care Unit** means a special room or area in a Hospital which includes: beds in a distinctly identifiable unit that are used only for critically ill or injured patients; a separate nursing staff, with a qualified Registered Nurse in 24-hour attendance while the unit is occupied ("Qualified" means the nurse has had special training in intensive care nursing); special supplies and equipment needed to care for critically ill or injured patients.

Patients in an Intensive Care Unit must be admitted by the attending Doctor for special care.

II. **Medical Emergency** means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

JJ. **Medically Necessary** means a service required to diagnose or to treat an illness or injury. To be Medically Necessary, the service must: be performed or prescribed by a Doctor; be consistent with the diagnosis and treatment of Your condition; be in accordance with standards of good medical practice; and not be for the convenience of the patient or his Doctor and is provided in the most appropriate setting.

To determine if services are Medically Necessary, the Company may require information related to (but not limited to): medical records, medical history, the service performed; the admission to the Hospital or Medical Care Facility; or continued care.

The determination that a service is a medical necessity is not a determination of the eligibility of the service under other provisions of this Benefit Description.

KK. **Medicare** means the Health Insurance for the Aged Act (Title XVIII of the Social Security Act Amendments of 1965, as amended now and in the future). "Medicare" includes any rules and regulations authorized by the Act and any law designed specifically to replace that Act.

LL. **Member** means the person named on the Identification Card. Member may also mean covered Dependents (as that term is defined herein) if the membership is one that covers a person or persons in addition to the person named on the Identification Card. If a Member is eligible for Medicare benefits and Medicare could be the primary payor for the Member's coverage as specified by applicable law, the Member must be enrolled in Medicare Part A (Hospital) and Part B (Medical).

MM. **Member-Only Coverage** means coverage that provides benefits for the person named on the Identification Card. This type of coverage is also referred to as "Single Coverage".

NN. **Member/Spouse Coverage** means coverage that provides benefits for the person named on the Identification Card and his/her spouse.

OO. Member/Child (Children) Coverage means coverage that provides benefits for the person named on the Identification Card and one or more children who qualify under the definition of Dependent.

PP. Member/Spouse/Child (Children) Coverage means coverage that provides benefits for the person named on the Identification Card, his/her spouse, and one or more children who qualify under the definition of Dependent. This type of coverage is also referred to as "Family Coverage".

QQ. Nervous or Mental Condition means a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association, except those shown as "not attributable to a mental disorder that are a focus of attention or treatment" are not covered.

RR. Non-Contracting Provider means an Eligible Provider who has not entered into a Contracting Provider Agreement directly with Blue Cross and Blue Shield of Kansas or through arrangements with another entity.

SS. Open Enrollment means the period of time during which eligible persons who have not previously enrolled with Blue Cross and Blue Shield of Kansas may do so. Open enrollment will occur at least once every twelve consecutive months and last for one month. The Open Enrollment period is established by the Underwriter of this Program and Blue Cross and Blue Shield of Kansas.

TT. Outpatient means a setting in which services are provided which is other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an Ambulatory Surgical Center, a clinic or a Physician's office.

UU. Palliative Care means treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the Hospice Patient and the Hospice Patient's Family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

VV. Prior Authorization means the Company has reviewed the necessary medical information and determined that proposed services are Medically Necessary. You are responsible that notification be made to the Company to obtain the Prior Authorization. If Your Doctor does not notify the Company, You must do so Yourself. Notice should be given to the Company at least 72 hours **in advance** of the planned admission and should include: the patient's name, date of birth, identification number, telephone number, address, Hospital name, planned date of admission, reason for admission, admitting physician's name. The notification can be telephoned to the Company at the telephone number on the Identification Card.

The Company has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. You, the Hospital and the admitting physician will be notified of the decision. Prior authorization of an admission or any service is related solely to the medical necessity of the service and is not a determination of the eligibility of the service under other provisions of this Benefit Description.

If You fail to obtain a necessary Prior Authorization, the Company will review that admission for medical necessity. No coverage will be provided for services determined by the Company to be medically unnecessary. Only that portion of the Inpatient claim that would normally be payable if services were received as an Outpatient will be covered.

WW. Proof of Loss means documentary evidence required by the Company to prove a valid claim exists. See Proof of Loss provision in item E. of Part IX – GENERAL INFORMATION section for information concerning the time frames within which Proof of Loss must be submitted to the Company.

XX. Reconstructive Surgery means reconstructive and related services that are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

YY. Rehabilitation Services means therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.

ZZ. Research-Urgent means a drug, device medical treatment or procedure that is otherwise excluded by this Benefit Description as Experimental or Investigational (see General Definitions and General Exclusions) but meet all the following criteria:

1. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.
    a. For purposes of Research Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.
    b. For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.
2. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment or where conventional treatment has failed or is not medically appropriate.
4. The3. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Member seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc or by an institution or entity for which the protocol for the drug, device, medical treatment or procedure has been approved by an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by Federal Departments and

Agencies that have adopted the Federal Policy for the Protection of Human Subjects.

4. The drug, device, medical treatment or procedure is not available free or at a reduced cost.
5. The drug, device, medical treatment or procedure is not excluded by another provision of this Benefit Description.

AAA. Swingbed means a skilled nursing facility bed in the Hospital, which allows for patients who are no longer receiving acute care and who would otherwise be discharged or moved to a nursing home to stay for an extended period of time due to their needs for further medical services.

BBB. Terminal Illness means an illness, of a Member, which has been diagnosed by a Physician and for which the Member has a prognosis of six months or less to live.

CCC. Underwriter of this Program means the State of Kansas.

DDD. Utilization Review means a claims review process of medical necessity and includes a review of: the need for Inpatient admissions; the appropriateness of the patient's length of stay; and the appropriate use of tests and procedures in relation to the diagnosis and treatment of the patient's condition.

The claims review is done by consulting practicing Doctors in cooperation with Your Doctor.

EEE. You and **Your** refer to the Member.

PART II

BASIC BENEFITS

"KANSAS CHOICE BENEFITS" SCHEDULE

NOTE: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

Benefit Period A calendar year (January 1 through December 31).

Prior Authorization Inpatient admissions to Hospitals and Medical Care Facilities require Prior Authorization by the Company unless the admission is for a life-threatening, limb-threatening or function-threatening condition, for obstetrical care, or occurs outside the 50 United States. All admissions for Nervous or Mental Conditions (Biologically Based or Non-Biologically Based) must be prior authorized by HMS by calling toll free 1-800-643-6154.

Note: The Prior Authorization Requirement does not apply in cases where Medicare is the primary payer or where this program is secondary payer.

	For services provided by a Blue Choice Provider or a Blue Plan Preferred Provider	**For services provided by a Non-Blue Choice Provider or a Non-Blue Plan Preferred Provider**
Copay for Inpatient Services	**$300** per admission then subject to the Coinsurance listed below.	**$600** per admission then subject to the Coinsurance listed below.
Copay for Hospital Emergency Room Services	**$100** per visit then subject to the Coinsurance listed below. This Copay is waived if the patient is admitted as an Inpatient within 24 hours to the same Hospital for treatment of the same condition.	**$200** per visit then subject to the Deductible and/or Coinsurance listed below. This Copay and the Deductible are waived for this service if the patient is admitted as an Inpatient within 24 hours to the same Hospital for treatment of the same condition.
Deductible per Benefit Period	**None**	**$500** per individual or **$1,500** for all covered family members. The Deductible applies to all services except for services provided for Outpatient Services for Nervous or Mental Conditions. Allowable Charges of all covered family members count toward the family Deductible; however, no individual Member shall satisfy more than the individual Deductible amount.
Coinsurance	**65% - 35%** After the Deductible has been met, **Blue Cross and Blue Shield will make payment for covered services at 65% of the Allowable Charge.** You will be responsible for the remaining 35% of the Allowable Charge. The Coinsurance applies to all services except for services provided for Outpatient Services for Nervous or Mental Conditions.	**50% - 50%** After the Deductible has been met, **Blue Cross and Blue Shield will make payment for covered services at 50% of the Allowable Charge.** You will be responsible for the remaining 50% of the Allowable Charge and any amounts above the Allowable Charge. The Coinsurance applies to all services except for services provided for Outpatient Services for Nervous or Mental Conditions.
Coinsurance Maximum per Benefit Period	**$2,200** per individual or **$4,400** for all covered family members. When an individual's 35% Coinsurance shares accumulate to $2,200 in a Benefit Period or when the coverage in aggregate reaches a maximum Coinsurance of $4,400 in a Benefit Period, benefits will be paid at 100% of the allowable charge for the remainder of the Benefit Period (Copayments still apply). Any amounts You pay to satisfy this Coinsurance Maximum for services provided by a Blue Choice Provider or a Blue Plan Preferred Provider do not apply toward the satisfaction of the Coinsurance Maximum for services provided by a Non-Blue Choice or a Non-Blue Plan Preferred Provider. The Coinsurance You pay for all covered family members count toward the family Coinsurance Maximum; however, no individual Member shall satisfy more than the individual Coinsurance Maximum amount.	**$3,650** per individual or **$7,300** for all covered family members. When an individual's 50% Coinsurance shares accumulate to $3,650 in a Benefit Period or when the coverage in aggregate reaches a maximum Coinsurance of $7,300 in a Benefit Period, benefits will be paid at 100% of the allowable charge for the remainder of the Benefit Period (Copayments still apply). Any amounts You pay to satisfy this Coinsurance Maximum for services provided by a Non-Blue Choice Provider or a Non-Blue Plan Preferred Provider do not apply toward the satisfaction of the Coinsurance Maximum for services provided by a Blue Choice or a Blue Plan Preferred Provider. The Coinsurance You pay for all covered family members count toward the family Coinsurance Maximum; however, no individual Member shall satisfy more than the individual Coinsurance Maximum amount.

	For services provided by a Blue Choice Provider or a Blue Plan Preferred Provider	For services provided by a Non-Blue Choice Provider or a Non-Blue Plan Preferred Provider
Inpatient Coverage for a Nervous or Mental Condition that is not Included in the Definition of Biologically Based Mental Illness	60 days per Member per Benefit Period subject to the Copay for Inpatient Services and the Coinsurance provisions. This maximum number of days per Benefit Period will be reduced by the number of days used for services provided by a Non-Blue Choice Provider or a Non-Blue Plan Preferred Provider. Each day of the available sixty (60) days will be exchangeable with partial hospitalization sessions in an approved partial day facility of not less than three (3) hours and not more than twelve (12) hours in any twenty-four (24) hour period, based upon the following exchange formula: If the charge for one partial hospitalization session does not exceed fifty (50) percent of the Allowable Charge for one Inpatient day of the average semi-private rate at the Hospital or Medical Care Facility where the session is conducted, the benefit exchange shall be two (2) partial hospitalization sessions equal to one day of Inpatient care. If the charge for one partial hospitalization session does exceed fifty (50) percent of the Allowable Charge for one Inpatient day of the average semi-private rate at the Hospital or Medical Care Facility where the session is conducted, the benefit exchange will be one partial hospitalization session equal to one day of Inpatient care.	30 days per Member per Benefit Period subject to the Copay for Inpatient Services and Coinsurance provisions. This maximum number of days per Benefit Period will be reduced by the number of days used for services provided by a Blue Choice Provider or a Blue Plan Preferred Provider.
Preventive Care Services	The first $450 of Allowable Charges per Member per Benefit Period will be paid at 100%. After the $450 has been paid, preventive care services are subject to the Coinsurance provision. The following are eligible preventive services: Well Woman Care (one office visit, one pap smear and STD testing when provided at the time of a well woman exam, limited to once per year). One routine mammogram per year. Well-Man Care (one office visit and one PSA blood test per year when provided at the time of a well man exam and STD testing when provided at the time of a well man exam, limited to once per year). One age-appropriate bone density screening per year. One routine age-appropriate colonoscopy per Member per lifetime. One periodic age appropriate physical exam per year. Standard diagnostic tests provided in connection with a periodic physical exam to include: General Health Panel Comprehensive Metabolic Panel Lipid Panel Urinalysis (UA) Fecal Occult Blood Cholesterol Creatinine HDL Cholesterol Thyroid Stimulating Hormone Triglycerides Complete Blood Count (CBC) One dietitian consultation per year. One routine hearing exam per year. One routine vision exam per year.	Not Covered

Inpatient Coverage for a Nervous Or Mental Condition that is Included in the Definition of Biologically Based Mental Illness	Hospital or Medical Care Facility services are subject to the Copay for Inpatient Services, the Benefit Period the Coinsurance provisions listed above. To receive this level of benefits the care must be coordinated through HMS. To obtain the required authorization call toll free 1-800-643-6154.
Childhood Immunizations	Benefit payments will be made at 100% of the Allowable Charge for a covered child from birth to 72 months of age for the following immunizations: at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib); three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella; and such other vaccines and dosages as may be prescribed by the Secretary of Health and Environment of the State of Kansas.
Medical Equipment	The Allowable Charge for medical equipment and eligible supplies will be subject to any applicable Deductible and/or Coinsurance until a maximum of $4,500 of Allowable Charges per Member per Benefit Period has been processed by the Company. After the maximum of $4,500 of Allowable Charges has been processed for medical equipment and eligible supplies, no benefits are available for medical equipment or eligible supplies until the next Benefit Period. Medical equipment and eligible supplies should be prior authorized by the Company. To obtain prior authorization, Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is processed. This maximum does not apply to covered contraceptive devices such as IUD's and diaphragms; diabetes equipment; oxygen or oxygen equipment; or supplies or equipment used in conjunction with intravenous drug treatment.
Facility Based Rehabilitation Services	Inpatient Services - The Member will be responsible for the applicable Copay per Inpatient Services per admission for Inpatient Rehabilitation Services. After the Copay has been met, benefits will be subject to the appropriate Coinsurance percentage and Coinsurance Maximum. To be eligible for benefits services require Prior Authorization; must be Medically Necessary; appropriate; result in continuous improvement and are not custodial/maintenance. Outpatient Services (in facilities such as Kansas Rehab Hospital) – Benefits will be subject to the appropriate Deductible, Coinsurance percentage and Coinsurance Maximum. To be eligible for benefits, services must be Medically Necessary, appropriate and provide continuous improvement. The Company will conduct periodic evaluations at 30 day intervals to assure continued medical necessity.
Office Based Rehabilitation Services	Benefits will be subject to the appropriate Deductible, Coinsurance percentage and Coinsurance Maximum listed below for services that are Medically Necessary, appropriate and result in continuous improvement. Office Based Rehabilitation Services are limited to a maximum of 30 visits per Member per Benefit Period. After the maximum of 30 visits per Member per Benefit Period has been met, benefits are not available for Office Based Rehabilitation Services for the remainder of that Benefit Period.
Home Health Care	The Allowable Charge for home health care will be subject to any applicable Deductible and/or Coinsurance until a maximum of $5,000 of Allowable Charges per Member per Benefit Period has been processed by the Company. After the maximum of $5,000 of Allowable Charges has been processed for home health care, no benefits are available for home health care until the next Benefit Period. Home health care should be prior authorized by the Company. To obtain prior authorization, Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is processed.
Hospice Care	The Allowable Charge for hospice care will be subject to any applicable Deductible and/or Coinsurance until a maximum of $7,500 of Allowable Charges per Member per lifetime has been processed by the Company. After the maximum of $7,500 of Allowable Charges has been processed under the hospice care provision, services will be processed according to the benefits and limitations of this Benefit Description other than those listed in the hospice care provision. Hospice care should be prior authorized by the Company. To obtain prior authorization, Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is processed.
Maximum Benefit	LIFETIME MAXIMUM FOR EACH MEMBER: All the benefits of this "Kansas Choice Program" are limited to $3,000,000 during the lifetime of the Member.

This Maximum Benefit Limit begins on the date that Your coverage becomes effective.

Exclusions (in addition to General Exclusions of Part III)

Benefits are not provided for services that are determined not to be Medically Necessary through the Utilization Review process. In the absence of a Utilization Review process, the Company has the right to determine when services are medically unnecessary.

Medicare Eligibility

If You or one of Your Dependents is eligible for Medicare benefits and Medicare is or would be primary payor for the individual's coverage as specified by applicable law, they must be enrolled in Medicare Part A (Hospital) and Part B (Medical). If they do not enroll in Medicare Part A and Part B, the benefits of this Benefit Description will be determined as if they were enrolled in Medicare Part A and Part B. This means that this Benefit Description will only pay the amount that would be paid if Medicare had made payment and You would be responsible for the amount that Medicare would have paid.

The "Kansas Choice" Program Basic Benefits apply only to Members and Dependents enrolled for such coverage.

All coverage is subject to the service having been ordered by a Professional Provider with the legal authority to order such service, furnished or performed and billed for by an Institutional or Professional Provider with the legal authority to provide such service, Medically Necessary and covered by the plan.

You have the right to select Your own provider. However, the Company does not guarantee the availability of any service and benefits shall be provided according to the cost-containment policies and procedures applicable to Contracting Providers, regardless whether Your Provider is actually contracting.

A. Covered Hospital and Medical Care Facility Services for an Inpatient when services are provided for a condition that is not a Nervous or Mental Condition.

Eligible Inpatient services are subject to Prior Authorization.

Except as limited, Covered Services by a Hospital or Medical Care Facility for an Inpatient include the following:

1. Room accommodation,* dietary and general nursing service, nursery care.
2. Intensive Care Unit facilities** and services.
3. Operating room service.
4. Delivery room service. (Including the obstetrical and delivery expenses of the birth mother of a child adopted and added to coverage within 90 days of birth of such child.)
5. Surgical preparatory room service and anesthesia recovery room service.
6. Clinical laboratory and pathological examinations.
7. Diagnostic radiology services and radiation therapy.
8. Drugs approved for use in the United States by the Federal Food and Drug Administration except drugs approved for experimental use and drugs for take-home use.
9. Surgical dressings, splints, and casts. Special appliances are excluded.
10. Chemotherapy other than High-Dose Chemotherapy, for malignant conditions. (See item I for High-Dose Chemotherapy with Hematopoietic Support benefits.)
11. Prostheses that require surgical insertion into the body and are furnished by the Hospital. This does not include artificial eyes, ears, and limbs.
12. Setups for intravenous solutions.
13. Setups for blood transfusions. (Blood plasma and packed platelets are included but blood and payments to donors of blood are not.)
14. Oxygen and use of equipment for its administration.
15. Radioactive isotopes.
16. Electroencephalograms (EEG's) and electrocardiograms (EKG's).
17. Inhalation therapy.
18. Physical or occupational therapy.
19. Anesthesia.
20. Hemodialysis. (Kidney transplants and hemodialysis care eligible for coverage by Medicare are excluded.)

***If a private room is occupied,** the difference between the charge for a private room and the Hospital's average semi-private room rate will be covered only when You must be isolated to prevent contagion or when Your isolation is required by law. In all other instances, the Allowable Charge for a private room will be the Hospital's average semi-private room rate.

To determine a Hospital's average **semi-private room** rate, rooms with two (2) or more beds will be used.

****If You occupy an Intensive Care Unit** when it is not Medically Necessary (see definition DD in Part I), but it is Medically Necessary for You to be in the Hospital, the Allowable Charge will be the Hospital's average semi-private room rate.

Note: Pursuant to Federal and state law, covered Inpatient services are available for at least 48 hours following a vaginal delivery and at least 96 hours following delivery by a cesarean section for a mother and newly born child in a Medical Care Facility as long as the membership type otherwise includes coverage for the mother and/or children. This requirement does not prevent the Professional Provider and the Member from deciding to shorten the Inpatient stay. The Company has the right to determine the medical necessity of additional coverage (beyond the 48-96 hours described above) for a mother and for the child. In the event that coverage hereunder provides benefits for only the mother of the newly born child, coverage must be changed to a type that provides benefits for Dependent children within the time period required for such change (as set forth in the Enrollment and Beginning of Coverage Section), for Inpatient services to be available for the newborn child(ren) beyond the initial 48 or 96 hour periods described above. Covered services received by the child prior to coverage being changed to a type that provides benefits for Dependent children, will be treated as though they were services received by the mother and any Deductible, Coinsurance or Copayment/Copay amounts otherwise applicable to the mother will be applied to expenses of the child.

B. Covered Hospital and Medical Care Facility Services for an Inpatient when services are provided for a Nervous or Mental Condition.

Eligible Inpatient services are subject to Prior Authorization by HMS.

Except as limited, Covered Inpatient Services by a Hospital for a Nervous or Mental Condition include all services listed in Part II, A.1 through 20.

1. Services provided for a Nervous or Mental Condition that is included in the definition of Biologically Based Mental Illness are available for benefits according to the payment provisions shown in the schedule.
2. Services provided for a Nervous or Mental Condition that is not included in the definition of Biologically Based Mental Illness are available for benefits according to the payment provisions and for the number of days shown in the schedule.

C. Covered Hospital Services for an Outpatient.

Except as limited, Covered Services by a Hospital for an Outpatient include all services listed in Part II, A.3 through 20 when the service is received in the Outpatient department of the Hospital (excluding those services eligible for coverage under a Prescription Drug

Expense Program or Dental Program sponsored by the Underwriter of this Program). This does not include those services provided for a Nervous or Mental Condition.

Outpatient services provided for a Nervous or Mental Condition are eligible for benefits according to the payment provisions shown in the section titled Outpatient Services For Nervous or Mental Conditions of this Benefit Description.

D. Covered Ambulatory Surgical Center Services.

Except as limited, the services listed in Part II, A.3 through 20 are covered when billed by an Ambulatory Surgical Center (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program).

E. Covered Professional Provider Services.

Except as limited, the covered Professional Provider services include:

1. Surgery and anesthesia services; treatment of fractures and dislocations; biopsies and aspirations; endoscopic (scope) procedures; sterilization procedures.
2. Maternity services. (Including the obstetrical and delivery expenses of the birth mother of a child adopted and added to coverage within 90 days of birth of such child.)
3. Medical (non-surgical) services for Inpatients in a Hospital or Medical Care Facility (including those services provided for a condition included in the definition of Biologically Based Mental Illness), as follows:
   a. Visits by the attending Doctor.

      Limitations:

      (1) For diagnosis or treatment of a Nervous or Mental Condition, Inpatient care benefits are limited to either one routine medical visit a day by Your Doctor or one psychiatric service each day, but not both.

         (a) Services provided for a Nervous or Mental Condition that is included in the definition of Biologically Based Mental Illness are available for benefits according to the payment provisions shown in the schedule.

         (b) Services provided for a Nervous or Mental Condition that is not included in the definition of Biologically Based Mental Illness are available for benefits according to the payment provisions and for the number of days shown in the schedule.

      (2) During a stay for surgery, Medical (Non-Surgical) Services given by a Doctor other than the surgeon will not be covered unless they are Medically Necessary.

      (3) If non-surgical treatment is given by two (2) or more Doctors on the same day, only one (1) Doctor will be paid for services.

   b. Consultations. The first visit of a Doctor to give professional advice about Your condition is covered if the visit is requested by the attending Doctor and Your condition requires special skill or knowledge.

      Limitations: The consultation benefit is normally limited to one (1) during each Hospital stay. However, additional consultations may be approved with individual consideration of Your condition.

      Exclusions: Consultations required by Hospital rules and regulations are not covered.

   c. Well Baby Care

      This covered service is for care of a well newborn during the mother's maternity Hospital stay. It includes the normal Inpatient medical care for a newborn.

4. Diagnostic radiology and laboratory services (including pap smears and mammograms); diagnostic radioisotope studies; Electroencephalograms (EEG's) and electrocardiograms (EKG's).
5. Home and office visits; injections (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program); allergy testing (except provocative testing and ingestion testing); eye exams (limited to one routine exam per Member per Benefit Period); hearing exams (limited to one routine exam per Member per Benefit Period). This includes those services provided for a Biologically Based Mental Illness.
6. Radiation therapy.
7. Transfusions (but not the cost of the blood itself).
8. Chemotherapy other than High-Dose Chemotherapy (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program) for malignant conditions. (See item I for High-Dose Chemotherapy with Hematopoietic Support benefits).
   a. Your Doctor's services for administering chemotherapy.
   b. The chemotherapy drugs that are injected or given intravenously or taken by mouth during the course of a professional treatment administered by Your Doctor (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program)
   c. Follow-up home and office visits for treatment of a reaction to chemotherapy.
   d. Any other services related to chemotherapy that are specifically stated as covered.
9. Covered Rehabilitation Services including Chiropractic care. Except as limited, the following Rehabilitation Services that are Medically Necessary, appropriate, and result in continuous improvement are covered on both an Inpatient and Outpatient basis:
   a. Physical medicine modalities, including but not limited to: correction or adjustment by manual, mechanical, electrical, or physical means (including the use of light, heat, water, or exercise) of structural imbalance, distortion, subluxation or misplaced tissue of any kind or nature of the human body.
   b. Physical therapy.

c. Occupational therapy. (The materials used are excluded.)

d. Speech therapy.

e. Respiratory therapy.

f. Neuropsychological testing.

g. Cardiac rehabilitation.

h. Pulmonary rehabilitation.

Note: (Cardiac and pulmonary rehabilitation programs are covered services only when provided by a provider whose program has been approved by Blue Cross and Blue Shield of Kansas.)

In addition to the above, the Company may approve the payment of benefits for Rehabilitation Services that are received in an institution other than a Hospital.

In order to obtain these benefits for Rehabilitation Services, You or Your Doctor must contact the Company **prior** to receipt of such services. The Company has the right to request and obtain whatever information it considers necessary to determine the appropriateness of such services. Such information may include but not be limited to, the condition of the Member for whom treatment is being requested, data indicating the charging practices of the facility in which treatment is being contemplated, and a written report of the recommended measurable treatment, goals and expected outcomes, including the proposed fees for the entire course of treatment. This information must be received by the Company **before** services are rendered. If such services are deemed appropriate by the Company, the Company will notify You, the facility and the admitting physician of approval.

Limitations:

a. Rehabilitation Services are subject to Prior Authorization and are covered only if they are expected to result in significant improvement in the Member's condition. The Company will determine whether significant improvement has, or is likely to occur based upon the medical information received from Your Doctor.

b. Second Opinions: The Company has the right to require the Member to obtain a second opinion regarding the appropriateness of the Rehabilitation Services being provided, from a Professional Provider of the Company's choice. The Company will be entirely responsible for the costs associated with such a second opinion; however, such amounts will not be applied toward the satisfaction of any Deductible or Coinsurance amounts otherwise required by this Benefit Description.

Exclusions:

a. Convalescent Care, Custodial/Maintenance Care or Rest Cures.

The Company will determine which services are Convalescent Care, Custodial/Maintenance Care or Rest Cures.

b. Vocational rehabilitation. Vocational rehabilitation is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patients to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation, to include but not limited to counseling, work trials and driving lessons.

c. Therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or re-injury.

d. Cognitive therapy. Cognitive therapy is a service provided to retrain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, inability to scan visually. Cognitive services may also be known as multi-sensory programs, applied behavioral analysis, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, developmental therapy, or another name. For the purposes of this Benefit Description, cognitive services have no correlation to neuropsychological testing.

F. Other Covered Services.

Except as limited, the services listed below are covered:

1. Oral Surgery and Other Related Benefits

The Health Plan will pay for the following limited dental services:

a. Administration of general anesthetic and facility charges determined by the Health Plan to be Medically Necessary for dental care, and provided to the following persons:

(1) Dependent children five years of age or under; or

(2) A Member who is severely disabled; or

(3) A Member who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

b. Benefits for oral surgical procedures of the jaw or gums will be covered for:

(1) Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(2) Removal of symptomatic exostoses (bony growths) of the jaw and hard or soft palate;

(3) Treatment of fractures and dislocations of the jaw and facial bones;

(4) Laceration of mouth, tongue or gums;

(5) Intraoral x-rays and pathology services in connection with covered oral surgery; and

(6) General anesthetic for covered oral surgery.

Note: All claims for treatment of accidental trauma to sound natural teeth should be processed by the State's dental plan. Services covered by the State's dental plan are not eligible for additional payment by the medical plan.

Exclusions: You do not have coverage for any service eligible for benefits under Your dental care

program sponsored by the underwriter of Your dental program.

2. Prescription drugs, supplies, and equipment for intravenous drug treatment.

   Prior Authorization: To obtain prior authorization for Total Parenteral Nutrition, Intravenous Antibiotics for Lyme Disease, or other prescription drugs associated with intravenous drug treatment Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is processed.

   Limitations: Benefits are limited to those eligible prescription drugs that have received FDA approval.

   Exclusions: Benefits are not available for prescription drugs, supplies or equipment for intravenous drug treatment if the service is eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program.

3. Injectable prescription drugs are eligible for coverage under this Benefit Description if they are not eligible for benefits under a Prescription Drug Expense Program sponsored by the Underwriter of this Program.

   Prior Authorization: To obtain prior authorization for Total Parenteral Nutrition, Intravenous Antibiotics for Lyme Disease, or other injectable prescription drugs your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is processed.

4. Allergy antigens.

5. Surgically inserted prostheses.

6. Orthotic and prosthetic devices, appliances and items when medically needed and not otherwise excluded herein. This includes items such as orthopedic braces, artificial limbs, artificial eyes. Coverage is available for breasts prostheses following a mastectomy. Benefits are limited to 2 prostheses per breast per Member per Benefit Period.

   Limitations:

   a. Benefits are not provided for eyeglasses and contact lenses (except the initial purchase of glasses or contact lenses within 6 months following surgery for cataracts, aphakia, or pseudophakia). An Insured under 12 years of age is eligible to receive benefits for the initial eyeglasses/contacts following surgery for cataracts and for subsequent eyeglasses/contacts when there is a diopter change of .25 diopter until they reach the age of 12 years.

   b. Benefits are not provided for hearing aids; hair prosthesis; dental plates, bridges or any dental prostheses, or dental braces or items of wearing apparel.

   c. Benefits are limited to the amount normally available for the initial basic (standard) appliance which allows necessary function.

   d. Charges for deluxe or electrically operated orthotic or external prosthetic appliances, devices, or items are not covered, beyond the extent normally allowed for basic (standard) appliances.

   e. The Company reserves the right to review and adjust the allowable amount at least annually.

   f. Benefits are not provided for individualized, custom fabricated shoe insert orthotic devices, appliances, and those available commercial over-the-counter foot devices.

7. Penile Prosthesis and other covered services for Physiological Impotence.

   Prior Authorization: Subject to advance approval by the Company, the benefits of this Benefit Description are provided for a penile prosthesis or other approved alternative therapies required for treatment of physiological (not psychological) impotence only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when the individual situation warrants coverage in the Company's opinion.

   To request advance approval, a written report prepared by Your Doctor must be submitted to the Company. The Company has the right to request and obtain medical information it considers needed to determine whether benefits should be approved or not.

   Limitations: The covered services listed in this PART II are eligible for physiological, not psychological impotence.

   Exclusions: Benefits are **not** provided for:

   a. services of sleep laboratories for nocturnal penile tumescence testing

   b. services eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program

   c. prescription drugs or medications used by the covered Member at home.

8. Medical Equipment. Equipment for use in Your home is covered if prescribed by a Doctor for use in the home; not provided by a Hospital; the item is a type of equipment that serves a medical purpose and is not an item that would ordinarily be of use to a person in the absence of a medical need. This includes items such as: hemodialysis equipment; wheelchairs; hospital-type beds. The benefit for an electrically operated wheelchair will be the amount normally available for a hand-operated wheelchair. Coverage is available for certain home use supplies as designated by the Company. A list of eligible supplies will be maintained by Blue Cross and Blue Shield of Kansas. Coverage is available for post-mastectomy bra/camisole/softee limited to a combination of 2 (either 2 bras or 2 camisoles or 2 softees or 1 bra and 1 camisole or 1 bra and 1 softee or 1 camisole and 1 softee) per Member per Benefit Period (a post-mastectomy bra is a bra that

is specifically designed and intended to support single or bilateral prostheses).

Limitations:

a. Items for comfort or convenience are not covered. Included within the definition of convenience items are:

(1) Those pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

(2) Those pieces of equipment designed to provide the walking capability for individuals with non-functioning legs.

(3) Benefits are limited to the amount normally available for the initial basic (standard) item which allows necessary function.

(4) Charges for deluxe or electrically operated medical equipment items are not covered beyond the extent allowed for basic (standard) items.

(5) The benefit for an electrically operated wheelchair will be the amount normally available for a hand-operated wheelchair.

b. The Company has the right to decide whether to provide for the rental or purchase of a covered item and apply rental payments to purchase. The Company also has the right to stop covering rental when the item is no longer Medically Necessary.

9. Diabetic Coverage. Coverage is only provided for the following when prescribed by a health care professional legally authorized to prescribe such services and supplies under the law and not eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program:

a. Equipment including glucometers, limited to those used exclusively with diabetes management; and

b. Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association; (2) is treated by a person certified by the national certification board for diabetes educators; or (3) is treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional for nutritional education.

Coverage for diabetes equipment is not subject to the Medical Equipment Benefit Period Maximum.

10. Artificial insemination will be covered subject to a maximum of three billable attempts per Benefit Period. There is no coverage for donor fees, collection and/or storage of sperm or any other related donor services. Prescription drugs provided in connection with infertility are not covered.

11. Abortion Coverage**:**

a. Abortions and abortion related services will be covered in the following:

(1) Where the life of the mother would be endangered if the fetus were carried to term;

(2) Termination of a tubal pregnancy;

(3) Prior to the eighth week of pregnancy, if the pregnancy is the result of an act of rape or incest; or

b. Medical complications that have risen from an abortion will be covered.

G. Ambulance Service.

Except as limited, Ambulance Service that is Medically Necessary is covered: to the nearest appropriate place of treatment following an Accidental Injury or Medical Emergency; to a Hospital for Hospital care as an Inpatient; from a Hospital where You have been an Inpatient; or for transfer of an Inpatient to another Hospital for care as an Inpatient.

Limitations: Ambulance Service benefits are limited to: the Allowable Charges (Section IV) that are within a 500 mile radius of the place where You are acquired; the least expensive means to meet the medical need.

H. Human Organ or Human Tissue Transplants.

Benefits are provided (subject to the prior authorization provision set forth below) for the following human organ transplants: Cornea; heart; heart-lung; kidney; pancreas; liver; lung (single or double).

Benefits for a human organ transplant will be available for a live donor (whether or not a Member), if the recipient is a Member, unless the donor has other coverage.

Prior Authorization Requirement for Human Organ or Human Tissue Transplants:

Benefits for the covered transplants (except benefits for cornea transplants) require advance written authorization from the Company. You or Your Doctor must give written notice to the Company at such time as You become a candidate for a human organ transplant or re-transplant. The Company has the right to require, request and obtain information from Your Doctors and other health care providers who will be involved in the performance of the transplant or re-transplant, and to then determine whether or not to authorize benefits. The Company's determination of whether or not to authorize benefits will be based on factors such as (but not limited to): qualifications of the facility where the procedures are to be performed; qualifications of the Doctors to be involved in the performance of the procedures; comparative costs of the Doctors to perform the procedures, the facility in which the procedures are proposed to be performed, and other factors. Notwithstanding any other provisions in this document addressing Allowable Charges to the contrary, the Company reserves the right to limit its allowance to the lowest allowable amount including organ or tissue acquisition cost which would be accepted by another facility that has agreed to contract with the Company to provide these services. Any balance will be the obligation of the Member.

Exclusions: There is no coverage hereunder for any transplants not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as

covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

I. High-Dose Chemotherapy with Hematopoietic Support (Commonly referred to as bone marrow transplant and/or Peripheral Stem Cell Transplant).

The benefits of this paragraph are available only when pre-certified by Blue Cross and Blue Shield of Kansas, and the condition for which the treatment is being proposed would not render the treatment non-covered through application of the Experimental or Investigational definition.

Prior Authorization Requirement for High-Dose Chemotherapy with Hematopoietic Support:

Benefits for the covered hematopoietic support with High-Dose Chemotherapy, require advance written authorization from the Company. You or Your Doctor must give written notice to the Company at such time as You become a candidate for the hematopoietic support with High-Dose Chemotherapy procedure. The Company has the right to require, request and obtain information from Your Doctors and other health care providers who will be involved in the hematopoietic support with High-Dose Chemotherapy procedure, and to then determine whether or not to authorize benefits. The Company's determination of whether or not to authorize benefits will be based on factors such as (but not limited to): qualifications of the facility where the procedures are to be performed; qualifications of the Doctors to be involved in the performance of the procedures; comparative costs of the Doctors to perform the procedures, the facility in which the procedures are proposed to be performed and other factors. Notwithstanding any other provisions in this document addressing Allowable Charges to the contrary, the Company reserves the right to limit its allowance to the lowest allowable amount including acquisition cost which would be accepted by another facility that has agreed to contract with the Company to provide these services. Any balance will be the obligation of the Member.

Limitations: The benefits for the costs associated with the donor search and acquisition of bone morrow or peripheral stem cells when a related donor is not available is limited to $35,000 per Member per transplant.

J. Case Management services as defined in Part I. Definitions.

K. Home Health Care and Private Duty Nursing Services

Covered home health services include services provided by a Medicare certified Home Health Agency for Medically Necessary services provided a Member who is Homebound.

Covered private duty nursing services include those services provided by a state licensed nursing agency or state licensed nurse for Medically Necessary services provided on an hourly basis to a Homebound Member.

A Member will be considered to be Homebound if they have a condition due to illness or injury which restricts their ability to leave their place of residence and/or leaving the home is medically contraindicated. The Company has the right to determine whether the patient is Homebound.

All home health care and private duty nursing services require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records for review to determine whether services are eligible under the Benefit Description.

Covered services include:

a. Nursing care provided in the Member's home by:

   (1) A registered nurse

   (2) A licensed practical nurse

   (3) A licensed vocational nurse.

b. Physical, occupational or speech therapy provided in the Member's home by:

   (1) A licensed physical therapist

   (2) A licensed occupational therapist

   (3) A licensed speech therapist.

c. Medically Necessary services provided in the Member's home by a licensed social worker.

The Company has the right to determine which services are Convalescent Care, Custodial/Maintenance Care or Rest Cures.

Exclusions:

a. Services provided by a member of the Member's immediate family;

b. Services provided by a person who normally lives in the Member's home; or

c. Services which are Convalescent Care, Custodial/Maintenance Care or Rest Cures.

L. Hospice Care

1. Election of Hospice Benefits

   In order for You to receive Hospice benefits for the covered services listed below, the Company must receive a copy of the Hospice Election Form and the Informed Consent Form from the Medicare certified Hospice. If these forms are not received, benefits of this Hospice Care provision will not be available and services You receive will be processed according to the benefits and limitations of this Benefit Description other than those listed in this Hospice Care provision.

   All Hospice Care services require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records for review to determine whether services are eligible under the Benefit Description.

2. Eligibility of Services

   a. Once Hospice benefits are elected, coverage for the terminal illness and related conditions is limited to the coverage listed in this Hospice Care provision unless specified otherwise.

b. Coverage under this Hospice Care provision is available only for Palliative Care. If Blue Cross and Blue Shield of Kansas determines the care provided is not Palliative Care, benefits of this Hospice Care provision cease to be available.

c. When covered services are not available from a Hospice provider (for example individual psychotherapy services) and the Member is referred to another provider of service, benefits are not available under this Hospice Care provision, except as provided under the description of Covered Services.

In situations b. and c. listed above when services are not eligible for benefits under the Hospice Care provision, the services will be processed according to the benefits and limitations of this Benefit Description other than those listed in this Hospice Care provision.

3. Covered Services

Covered Hospice Care includes services provided by a Medicare certified Hospice or other facility or Professional Provider under the direction of a Medicare certified Hospice and not charging for services separately from the charges made by the Hospice. Covered services include the following when provided for routine home care according to the Hospice Care Plan and provided by the Hospice for the terminal illness:

a. Nursing care.

b. Home health aide services.

c. Social work services.

d. Pastoral services.

e. Volunteer support.

f. Bereavement services.

g. Counseling services.

h. Dietary and nutritional counseling/services.

i. All drugs, medical supplies, and equipment related to the terminal illness (excluding those services eligible for coverage under a Prescription Drug Expense Program sponsored by the Underwriter of this Program).

j. Speech therapy.

k. Occupational therapy

l. Physical therapy.

m. Lab fees.

n. Medical equipment.

o. Educational services.

p. Other services and supplies provided through the Medicare certified Hospice (excluding Inpatient Hospital care and Inpatient or Outpatient physician's visits) recommended by a Doctor.

M. Research-Urgent Benefits as defined in Part I. Definitions.

N. Reconstructive Surgery

For purposes of this provision, reconstructive surgery means reconstructive and related services that are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

Benefits are available for:

1. Reconstructive repair of an Accidental Injury.
2. Reconstructive breast surgery coinciding with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed to produce a symmetrical appearance.
3. Repair of congenital abnormalities and hereditary complications or conditions, limited to:
   a. Cleft lip or palate.
   b. Birthmarks on head or neck.
   c. Webbed fingers or toes.
   d. Supernumerary digits or toes.
4. Reconstructive and related services that are performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

KANSAS CHOICE PROGRAM

Outpatient Services For Nervous or Mental Conditions

A. Definitions

In addition to the definitions of Part I, the following definition is applicable to this section.

1. **Medical Care Facility** for the purposes of this section, means any of the following facilities that are licensed by the State of Kansas to provide Outpatient diagnosis and/or treatment of a Nervous or Mental Condition:
   a. An alcoholic treatment facility;
   b. A drug abuse treatment facility;
   c. A psychiatric hospital;
   d. A community mental health center.

B. Covered Providers

Regardless of any other provision in this Benefit Description, benefits are not provided for services when provided by a Professional Provider as defined in this Benefit Description, but benefits are provided for services by the following (referred to as "Covered Providers" in this section):

1. A Hospital.
2. A Medical Care Facility.
3. A licensed Doctor of Medicine, or Doctor of Osteopathy.
4. A psychologist licensed to practice under the laws of the State of Kansas.
5. A Licensed Specialist Clinical Social Worker authorized to engage in private, independent practice under the laws of the State of Kansas.
6. Advanced registered nurse practitioner.

C. Covered Services

Except as limited, benefits are provided for the costs of treatment by Covered Providers (as defined above) for Nervous or Mental Conditions.

D. Benefits

1. The Allowable Charge under this section is the Allowable Charge for Professional Providers of services as set forth in this Benefit Description. The foregoing reference to Professional Providers does not mean that anyone other than the Covered Providers identified above may provide services which would be covered under this section. The covered services provided and billed for by a Medical Care Facility or Hospital will be paid on the same basis as Professional Providers of services.
2. When You receive service for any condition included in the definition of Nervous or Mental Condition from a Blue Choice or Blue Plan Preferred Provider, the benefits for each Member are: The first three (3) visits in each Benefit Period - 100% of the Allowable Charge (The number of Blue Choice Provider and Blue Plan Preferred Provider visits available for payment at 100% of the Allowable Charge will be reduced by the number of Non-Blue Choice and Non-Blue Plan Preferred Provider visits paid at 100% of the Allowable Charge);

   NOTE: In the case of group counseling sessions, benefits would be available as follows: the first six (6) sessions will be covered at 100% of the Allowable Charge. (The number of Blue Choice Provider and Blue Plan Preferred Provider visits available for payment at 100% of the Allowable Charge will be reduced by the number of Non-Blue Choice and Non-Blue Plan Preferred Provider visits paid at 100% of the Allowable Charge).

   If services are provided for a condition that is included in the definition of Biologically Based Mental Illness, services provided for the remainder of the Benefit Period will be paid according to the Blue Choice Provider/Blue Plan Preferred Provider Level Of Benefits listed in the ”KANSAS CHOICE BENEFITS” SCHEDULE. To receive this level of benefits the care must be coordinated through HMS.

   If services are provided for a condition that is **not** included in the definition of Biologically Based Mental Illness, the next 22 visits in each Benefit Period - 100% of the Allowable Charge after a $25 Copayment per visit. (The 22 Blue Choice Provider/Blue Plan Preferred Provider visits available for payment at 100% of the Allowable Charge after a $25 Copayment per visit has been applied will be reduced by the number of Non-Blue Choice Provider/Non-Blue Plan Preferred Provider visits paid at 50% of the Allowable Charge).

   After the first 25 visits have been processed, additional visits provided by a Blue Choice Provider or a Blue Plan Preferred Provider will be paid at 50% of the Allowable Charge for the remainder of the Benefit Period.

   NOTE: In the case of group counseling sessions, benefits would be available as follows: the next forty-four (44) sessions will be covered at 100% of the Allowable Charge after a $12.50 Copayment per session. For the purposes of determining maximum Outpatient benefits, each two group counseling sessions will reduce the total number of Outpatient visits available by one (1) visit. Likewise, each Outpatient visit will reduce the number of available group counseling sessions by two (2) sessions. Additional visits during the Benefit Period will be paid at 50% of the Allowable Charge. (The 44 Blue Choice Provider/Blue Plan Preferred Provider visits available for payment at 100% of the Allowable Charge after a $12.50 Copayment per visit has been applied will be reduced by the number of Non-Blue Choice Provider/Non-Blue Plan Preferred Provider visits paid at 50% of the Allowable Charge).

3. Non-Blue Choice Provider/Non-Blue Plan Preferred Provider services:

   When You receive service from a Non-Blue Choice Provider/Non-Blue Plan Preferred Provider for any condition included in the definition of Nervous or Mental Condition the benefits for each Member are: The first three (3) visits in each Benefit Period - 100% of the Allowable Charge (The number of Non-Blue

Choice Provider/Non-Blue Plan Preferred Provider visits available for

payment at 100% of the Allowable Charge will be reduced by the number of Blue Choice Provider/Blue Plan Preferred Provider visits paid at 100% of the Allowable Charge).

NOTE: In the case of group counseling sessions, benefits would be available as follows: the first six (6) sessions will be covered at 100% of the Allowable Charge. (The number of Non-Blue Choice Provider and Non-Blue Plan Preferred Provider visits available for payment at 100% of the Allowable Charge will be reduced by the number of Blue Choice and Blue Plan Preferred Provider visits paid at 100% of the Allowable Charge).

If services are provided for a condition that is included in the definition of Biologically Based Mental Illness, services provided for the remainder of the Benefit Period will be paid according to the Non-Blue Choice Provider/Non-Blue Plan Preferred Provider Level Of Benefits listed in the "KANSAS CHOICE BENEFITS" SCHEDULE. To receive this level of benefits the care must be coordinated through HMS.

If services are provided for a condition that is **not** included in the definition of Biologically Based Mental Illness, the next 22 visits in each Benefit Period - 50% of the Allowable Charge. (The 22 Non-Blue Choice Provider/Non-Blue Plan Preferred Provider visits available for payment at 50% of the Allowable Charge will be reduced by the number of Blue Choice Provider/Blue Plan Preferred Provider visits paid at 100% of the Allowable Charge after the $25 Copayment per visit has been applied).

After the first 25 visits have been processed, no benefits are available for additional visits provided by a Non-Blue Choice Provider or a Non-Blue Plan Preferred Provider.

NOTE: In the case of group counseling sessions, benefits would be available as follows: the next forty-four (44) sessions will be covered at 50% of the Allowable Charge. For the purposes of determining maximum Outpatient benefits, each two group counseling sessions will reduce the total number of Outpatient visits available by one (1) visit. Likewise, each Outpatient visit will reduce the number of available group counseling sessions by two (2) sessions. (The 44 Non-Blue Choice Provider/Non-Blue Plan Preferred Provider visits available for payment at 50% of the Allowable Charge will be reduced by the number of Blue Choice Provider/Blue Plan Preferred Provider visits paid at 100% of the Allowable Charge after the $12.50 Copayment per visit has been applied).

4. Lifetime Maximum Benefit Limit - There is no lifetime maximum benefit limit for services covered under this section unless specified in items D.2. or D.3. above.

5. Any Deductible, and/or Coinsurance of Your basic Benefit Description does not apply to this benefit unless specified in items D.2. or D.3. above.

F. Limitations and Exclusions

In addition to the General Exclusions of Part III, these exclusions also apply:

1. Services received while You are an Inpatient in a Hospital or Medical Care Facility or while You are receiving partial day hospitalization sessions.

2. Non-medical services. This includes (but is not limited to): legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services.

3. Services of volunteers.

4. Any assessment against any Member required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified by Kansas statutes.

5. Disorders specified in the Diagnostic and Statistical Manual of the American Psychiatric Association shown as "not attributable to a mental disorder that are a focus of attention or treatment".

6. Evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

PART III

GENERAL EXCLUSIONS

The following General Exclusions apply to all Blue Cross and Blue Shield of Kansas coverages described in this Benefit Description.

Additional limitations and exclusions that apply just to a certain coverage are shown with that coverage description.

A. Benefits will not be provided for:

1. Charges for services that are not listed as Covered Services.
2. Services for injuries or diseases related to Your job to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement. In addition, if You are covered by a worker's compensation program which limits benefits if other than specified providers of health services are used and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
3. Benefits of this Benefit Description will not duplicate benefits provided under Federal, State, or local laws, regulations or programs. Examples of such programs are: Medicare; Tri-Care; services in any veteran's facility when the services are eligible for coverage by the government. This Benefit Description will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

   This exclusion applies whether or not You choose to waive Your rights to these services.
4. Benefits for any service that Federal or State laws require be made available through a child's school district pursuant to an Individual Education Plan (IEP).

   This exclusion applies whether or not You choose to waive Your rights to these services.
5. Services not prescribed by an Eligible Provider or continued after an Eligible Provider has advised that further care is not necessary.
6. Services that are not Medically Necessary, as defined in Part I.
7. Hospital, Doctor, or other health services when the patient is unnecessarily admitted to and/or retained in the Hospital for services and evaluations that could satisfactorily be made on an Outpatient basis. The services that would be covered as an Outpatient will be covered.
8. Laboratory services performed by an independent laboratory that is not approved by Medicare.
9. Any drug, device or medical treatment or procedure that is Experimental or Investigational as defined in Part I, Definitions or that does not have FDA approved indications.
10. Procedures and diagnostic tests that are considered to be obsolete by a professional medical-advisory committee. All services primarily related to such procedures and diagnostic tests are also excluded.
11. Services for diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
12. Health services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense payment provision (by whatever terminology used - including such benefits mandated by law) of any automobile insurance policy. The excluded expenses cannot be used for any purpose under this Benefit Description. If You enter into a settlement giving up Your right to recover past or future medical benefits provided in connection with the accidental bodily injury the Company will not pay past or future medical benefits that are the subject of or related to that settlement.
13. Blood, payment to donors of blood or charges for storage of the Member's own blood.
14. Services provided directly for or relative to cosmetic surgery or reconstructive surgery unless stated otherwise in the Covered Health Services section.
15. Convalescent Care, Custodial/Maintenance Care, or Rest Cures.
16. All services provided directly for or relative to transplant procedures other than those specifically set out as Benefits.
17. Services provided directly for or relative to any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services. Two examples of mass screening are mobile vans and school testing programs.
18. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.
19. Acupuncture. Hospital admissions for the primary purpose of performing acupuncture, and acupuncture services provided to Inpatients and Outpatients.
20. Services or supplies provided directly for or relative to sex changes, sexual dysfunctions or inadequacies. All related complications are also excluded. (See Basic Benefits for exception for penile prosthesis and other covered services required for physiological [not psychological] impotence.)
21. Services provided directly for or relative to the reversal of voluntary sterilization procedures. (Services provided directly for or relative to the sterilization itself are covered services.)
22. Charges for autopsies.
23. Transportation other than covered Ambulance Services.
24. Hospital, Medical Care Facility, or Ambulatory Surgical Center services or charges for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, or air conditioning provided on an optional basis.
25. Doctor or other Professional Provider services or charges for:

a. Services where the provider would normally make no charge.

b. Travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone charges for missed appointments, services provided through e-mail or electronic communications. For the purpose of this provision electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

c. Services by an Immediate Relative or Member of Your Household.

"Immediate relative" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service.

"Member of Your household" means anyone who lives in the same household or who was claimed as a tax deduction for the year during which the service was provided.

d. Dental care other than that listed as a Covered Service.

e. Eyeglasses and contact lenses, servicing of visual corrective devices, or consultations related to such services; orthoptic training and visual training.

f. Hearing aids, or the fitting thereof.

26. Any reduction made in a charge for a covered service due to the provider's being non-contracting is not covered, i.e., not used to meet any Deductible, maximum Coinsurance, or considered allowable in any way.

27. Charges for completion of insurance claim forms.

28. Refractive procedures including: radial keratotomies, astigmatic keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature.

29. Medical, surgical, or dental treatment for or related to temporomandibular joint (jaw hinge) dysfunction syndrome or orthognathic procedures.

30. In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure or infertility drugs, except for those benefits for artificial insemination as set forth in the other covered services section of this Benefit Description.

31. Any service or supply provided directly for or relative to the medical management of obesity. This includes but is not limited to surgery, office visits, hospitalization, laboratory or radiology services, prescription drugs, medical weight reduction programs, nutrients and diet counseling.

32. Automatic external defibrillators.

33. Prescription drugs utilized for stimulation of hair growth or other cosmetic purposes.

34. Services performed and billed directly (including billings by billing services or assignees of claims) by a Registered Nurse are excluded from coverage except coverage is available as provided in the covered services section for Home Health Care and Private Duty Nursing Services as well as anesthesia services performed and billed directly by a Registered Nurse performing the services. Notwithstanding the above, coverage is also provided for services performed and billed directly by an advanced registered nurse practitioner.

35. Enteral nutritional supplements which do not qualify as a Prescription Drug as defined herein.

36. The only educational benefits provided under this Benefit Description are those pertaining to diabetic education as specified in the Other Covered Services section.

37. Individualized, custom fabricated shoe insert orthotic devices, appliances, and those available commercial over-the-counter foot devices.

38. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

39. Drugs for take home use and insulin.

40. Compound medications which are injected or completely used up at the time and place of service and which do not contain an active ingredient with a valid NDC number or which are used for other than an FDA approved indication.

41. Any food item including breast milk, formulas and other nutritional products.

42. Services provided directly for or relative to an injury sustained during the commission of an illegal act.

43. Court ordered services.

44. Services, supplies or prescription drugs for the maintenance of addiction.

45. Abortions except in those situations specified set forth in the Other Covered Services section of this Benefit Description.

46. Room and board charges in a Swingbed situation once the patient is no longer receiving acute care.

47. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders which are "not attributable to a mental disorder that are a focus of attention", e.g. marriage counseling. This exclusion applies to all benefits provided in this document, it is not limited to those benefits listed for Nervous or Mental Conditions.

48. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.

49. Human growth hormone therapy or other drugs used to treat growth failure.

50. Diagnostic tests and evaluations that are performed solely for the purpose of issues at dispute in the context of legal proceedings such as an issue of custody, visitation, severance of parental rights, or damages in any kind of personal injury action.

51. Prescription drugs utilized primarily for the treatment of obesity. This exclusion applies even if the drug is prescribed for purposes other than the treatment of obesity.

52. Genetic Molecular Testing except when there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

    As used herein, “Genetic Molecular Testing”, means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

53. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

54. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. “Provisional” means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

55. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Member failing to complete the initial treatment plan.

56. Chemotherapeutic agent(s) inserted into a periodontal pocket.

57. Communication devices designed and used for enhancing or enabling communication except for an electrolarynx.

58. Services for smoking cessation programs, pain management programs, and childbirth education classes.

PART IV

ALLOWABLE CHARGES AND PAYMENT OF CLAIMS

A. Contracting Providers in the Company Service Area for other than Prescription Drugs or Sleep Studies: In this section, the term Contracting Provider will be used to mean any provider of health care services who has contracted with Blue Cross and Blue Shield of Kansas (hereafter called "the Company") or another entity on behalf of Blue Cross and Blue Shield of Kansas. Through their contracts with the Company or the other entity, such providers agree to accept the Company's or other entity's determination of a Member's benefits (as set out in the Contracting Provider Agreement) as payment in full for covered services received by the Member, except that the Member is responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, non-covered services, private room charges in excess of the allowable amount stated in the Member's Benefit Description, and amounts in excess of any other benefit limitations of the Member's Benefit Description. The Contracting Providers include (but are not limited to): Eligible Providers as defined in Part I. A list of the Contracting Providers will be made available to Members.

A Member's benefits will be paid directly to the Contracting Provider.

B. Contracting Providers of Blue Cross and Blue Shield of Kansas for Limited Services for other than Prescription Drugs or Sleep Studies: In certain situations, Institutional Providers may be Contracting Providers for only a limited set of services, e.g., chemical dependency treatment or Outpatient treatment of Medical Emergencies and Accidental injuries. In such cases, such an Institutional Provider will be treated as a Contracting Provider for the purpose of acceptance of Allowable Charges established by the Company as payment in full, and direct payment of benefits. For services other than the limited set of services identified above, these Institutional Providers will be considered Non-Contracting. When You receive services for which the provider is contracting, Your benefits will be paid directly to the Contracting Provider.

When You receive services for which the provider is non-contracting, Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.

C. Non-Contracting Providers in the Company Service Area for other than Prescription Drugs or Sleep Studies: In order to receive the maximum benefits, You need to obtain covered services from a Contracting Blue Choice Provider. Receiving covered services that are not provided in connection with a Medical Emergency situation will make You responsible for any amount over the allowable charge as determined in items 1. through 5. of this section and the increased out-of-pocket expenses for the use of a Non-Blue Choice Provider. If the Member receives service from a provider located within the Company Service Area who has not contracted with Blue Cross and Blue Shield of Kansas the Allowable Charges (before application of any Deductible, Copayment/Copay, Coinsurance, or benefit limits called for by the Member's Benefit Description) will be determined as follows and the Member is responsible for any difference between the Allowable Charge and the provider's actual charge:

The allowable charge is the provider's actual charge for the service up to 80% of the maximum amount allowable for the same service or procedure provided by a Contracting Provider of Blue Cross Blue Shield of Kansas with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure.

"Same Service" as used in this section C shall be determined on the basis of the intended result of the service and not the technical methodology used by the provider to perform that service.

When a covered service that is required for a Medical Emergency, is a service for which a Blue Choice provider does not have the equivalent equipment available or is a service that is not provided by a Blue Choice Provider is provided by a Non-Contracting Provider, the Allowable Charge will be the provider's actual charge for the service up to the maximum amount allowable for the same service provided by providers that are Contracting Institutional Providers of the Company that are the same kinds of providers or Contracting Professional Providers of the Company with the same licensure or certification.

All reimbursement identified in this Section C is paid according to the cost-containment policies and procedures applicable to Contracting Providers. If You receive services from a Non-Contracting Provider, You will be responsible for payment for services for which payment is not made by the Company due to a cost-containment policy or procedure applicable to a Contracting Provider of the same licensure providing the same service. Such cost-containment policies include, but are not limited to, determinations by the Company that the services provided are of such a nature that they should be considered one service with a single payment, or that the billing for services inappropriately categorized the nature of the services performed, in the opinion of the Company, and payment should be made for a different type or different intensity of service.

A Member's benefits for services received from a Non-Contracting Provider will be paid directly to the Member. Such benefits are personal to that Member and cannot be assigned to any other person or entity.

D. Covered Provider in the Company Service Area who are in a class of providers that are not offered Contracting Provider status:

Your benefits will be paid to You unless submitted by the provider on Your behalf or assigned by You to the provider. To assign benefits, an assignment statement bearing the original signature of the Member must be received with each claim submitted.

E. Eligible Providers located outside the Company Service Area for other than Prescription Drugs or Sleep Studies

1. **In areas where the Company offers Contracting Provider status directly or through arrangements with another entity (other than another Blue Cross and/or Blue Shield Company) to a class or classes of providers (such as Hospitals and/or physicians).**

   a. When a provider in such class contracts with the Company or another entity on behalf of

the Company, the provisions in Section A apply.

b. When a provider in such class does not contract with the Company or another entity on behalf of the Company, the provisions in Section C apply.

2. **For arrangements other than those set forth in item E.1.**

a. Under the BlueCard program, when You obtain health care services outside the geographic area Blue Cross and Blue Shield of Kansas serves, the amount You pay for covered services is calculated on the **lower** of:

(1) The billed charges for Your covered services, or

(2) The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Blue Cross and Blue Shield of Kansas.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with Your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with Your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

Statutes in a small number of states may require Host Blue to use a basis for calculating Member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual Blue Card method noted above in paragraph one of this section or require a surcharge, Blue Cross and Blue Shield of Kansas would then calculate Your liability for any covered health care services in accordance with the applicable state statute in effect at the time You received Your care.

If You would like to know the specific basis used for calculating Member liability for covered services received outside the Company Service Area, You may contact the Blue Cross and Blue Shield of Kansas Customer Service Center.

b. In instances where the Member receives service from a provider which is not contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, the Allowable Charges (before application of any Deductible, Coinsurance, Copayment/Copay, or benefit limits) will be determined as follows and the Member is responsible for any difference between the Allowable Charge and the provider's actual charge:

The allowable charge is the provider's actual charge for the service up to the maximum amount allowable for the same service or procedure provided by a Contracting Provider of Blue Cross Blue Shield of Kansas with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure.

"Same service" as used in this Section E shall be determined on the basis of the intended result of the service and not the technical methodology used by the provider to perform that service.

In instances where the Member receives service from a provider that is contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, payment will be made directly to the provider.

A Member's benefits for services received from a Non-Contracting Provider will be paid directly to the Member. Such benefits are personal to that Member and cannot be assigned to any other person or entity.

F. Prescription Drugs.

The Allowable Charge is the provider's charge for the prescription drug.

A Member's benefits for prescription drugs will be paid directly to the Member. Such benefits are personal to that Member and cannot be assigned to any other person or entity.

G. Sleep Studies

1. **Sleep Studies provided within the Company Service Area.**

a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) or Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Board Certified in Sleep Medicine** – The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine Allowable Charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in this Benefit Description, and amounts in excess of any other benefit limitations of this Benefit Description.

b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American**

Academy of Sleep Medicine (AASM) or Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Not Board Certified in Sleep Medicine – The Allowable Charge will be the provider's actual charge for covered services up to 60% of the maximum amount allowable to a Contracting Provider that is accredited by the American Academy of Sleep Medicine or Board Certified in Sleep Medicine. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in this Benefit Description, and amounts in excess of any other benefit limitations of this Benefit Description.

c. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Board Certified in Sleep Medicine** – The Allowable Charge will be the provider's actual charge for covered services up to 80% of the maximum amount allowable as determined in item G.1.a. above.

d. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Not Board Certified in Sleep Medicine –** The Allowable Charge will be the provider's actual charge for covered services up to 80% of the maximum amount allowable as determined in item G.1.b. above.

2. **Sleep Studies provided outside the Company Service Area.**

a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) or Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Board Certified in Sleep Medicine** – The Allowable Charge will be the provider's actual charge up to the maximum amount allowable as determined as described in item E.2.a. above.

b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Board Certified in Sleep Medicine** – The Allowable Charge will be the provider's actual charge for covered services up to 60% of the maximum amount allowable as determined in E.2.a. above. You will be responsible for the difference between the Allowable Charge and the maximum amount allowable as determined in item E 2.a. above.

c. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Board Certified in Sleep Medicine** – The Allowable Charge will be the provider's actual charge for covered services up to 80% of the maximum amount allowable as determined in item G. 1a. above.

d. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Board Certified in Sleep Medicine** – The Allowable Charge will be the provider's actual charge for covered services up to 80% of the maximum amount allowable as determined in item G.1.b. above.

In instances where the Member receives service from a provider that is contracting with the Company or the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, payment will be made directly to the provider.

A Member's benefits for services received from a Non-Contracting Provider will be paid directly to the Member. Such benefits are personal to that Member and cannot be assigned to any other person or entity.

H. Any Benefits Unpaid At Your Death May Be Paid To Your Estate

If benefits are payable to Your estate, the Company may initially pay up to $1,000 to anyone related to You by blood or marriage, whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

PART V

COORDINATION OF THIS BENEFIT DESCRIPTION'S BENEFITS WITH OTHER BENEFITS

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules listed below determine which Plan will pay as the Primary Plan. The Primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total allowable expense.

A. Definitions

1. A **"Plan"** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate Contracts, Certificates or Benefit Descriptions are used to provide coordinated coverage for Members of a group, the separate Contracts, Certificates or Benefit Descriptions are considered parts of the same Plan and there is no COB among those separate Contracts, Certificates or Benefit Descriptions.

   a. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; and governmental benefits, as permitted by law.

   b. "Plan" does not include: individual insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; group or group-type accident only coverage, benefits for non-medical components of group long-term care policies; Medicare, Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under a. or b. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Member.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

3. **"Allowable Expense"** means a health care service or expense, including deductibles, coinsurance and copayment amounts, that is covered at least in part by any of the Plans covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

   a. If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the Member's stay in a private hospital room is Medically Necessary, or one of the Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.

   b. If a Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, or if one Plan calculates its benefits or services on the basis of usual and customary fees and another Plan provides its benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an Allowable Expense.

   d. The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a Member has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. **"Closed Panel Plan"** is a Plan that provides health benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. **"Custodial Parent"** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

B. Order Of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan

provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

3. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

4. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

   a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

   b. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:

      (1) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

         - The parents are married;
         - The parents are not separated (whether or not they ever have been married); or
         - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

      (2) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

      (3) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

         - The Plan of the custodial parent;
         - The Plan of the spouse of the custodial parent;
         - The Plan of the noncustodial parent; and then
         - The Plan of the spouse of the noncustodial parent.

   c. Active or inactive employee. The Plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined in item B.4.a. above.

   d. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   e. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

   f. If the preceding rules do not determine the Primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

C. Effect On The Benefits Of This Plan

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

   a. Determine its obligation to pay or provide benefits under its contract;

   b. Determine whether a benefit reserve has been recorded for the covered person; and

   c. Determine whether there are any unpaid allowable expenses during that claim determination period.

   If there is a benefit reserve, the Secondary Plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

2. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel

provider, benefits are not payable by one closed panel plan, COB shall not apply between that Plan and other closed panel plans.

D. Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

E. Facility Of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. Right Of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PART VI

ENROLLMENT AND BEGINNING OF COVERAGE

Eligibility

A. Member

To be eligible to enroll as a Member, an individual must:

meet and continue to meet all eligibility requirements for participation in the health benefit program established by the Underwriter of this Program; and

B. Dependent

To be eligible to enroll as a Dependent, an individual must:

meet and continue to meet all eligibility requirements for participation in the health benefit program established by the Underwriter of this Program.

C. Adding Newly Eligible Dependents to an Existing Membership

When a new Dependent is to be added to a membership, the Member named on the Identification Card should notify the Underwriter of this Program in writing of the Dependent's name, date of birth, sex and relationship to the Member and the Dependent's social security number. Notification must be made according to the enrollment requirements established by the Underwriter of this Program.

The Underwriter of this Program requires that each covered person be recorded on the Underwriter of this Program's records. Claims for Dependents not on record with the Underwriter of this Program will be denied until it has been established by the Underwriter of this Program that the person is an eligible Dependent.

D. Dependent coverage pursuant to a Qualified Medical Child Support Order:

Coverage will be effective on the first day of the month following date on which the Underwriter of this Program qualifies the Order. Medical Child Support Orders must be qualified by the Underwriter of this Program pursuant to specifications of Federal and state law. The procedure for qualification is to timely submit the Medical Child Support Order to the Underwriter of this Program for initial qualification or rejection. The Underwriter of this Program will forward the Order to the Company for an Identification Card, Benefit Description and claim form to be issued to the Alternate Recipient.

E. Effective Date of Coverage

Coverage of a Member or a Dependent shall become effective at 12:01 a.m. on the first day of compliance with the eligibility requirements of the Underwriter of this Program and subject to applicable payment by the Underwriter of this Program.

If a Member or a Dependent is confined in a Hospital on the effective date of coverage, Blue Cross and Blue Shield of Kansas will cover the Hospital confinement (beginning on the effective date of this coverage), benefits may be subject to the Non-Duplication of Benefits provisions as specified in this Benefit Description. The Member or Dependent must notify Blue Cross and Blue Shield of Kansas of the Hospital confinement within forty-eight (48) hours of the effective date or as soon thereafter as reasonably possible.

PART VII

TERMINATION OF ELIGIBILITY

A. Situations when coverage is terminated. The eligibility of an individual Member will terminate in the following situations:

1. When the Company is notified that a Member is no longer eligible for this Program.
2. Termination of marriage. The coverage of the husband or wife of the person named on the Identification Card ends on the last day of the month in which the divorce or legal separation was granted by court action.
3. Dependent Children who no longer meet the requirements of an eligible Dependent as established by the Underwriter of this Program.
4. If a Member permits the use of their or any other Member's Blue Cross and Blue Shield of Kansas Identification Card by any other person, or uses another Member's card, all rights of the Member(s) may be terminated effective immediately upon written notice.
5. If a Member fails to disclose information requested by Blue Cross and Blue Shield of Kansas or misrepresents information provided to Blue Cross and Blue Shield of Kansas, or is abusive toward providers and Company personnel in applying for or seeking any benefits under this Benefit Description, then the rights of such Member under this Benefit description may be terminated effective immediately upon written notice. At the effective date of such termination, prepayments received on account of such terminated Member applicable to periods after the effective date of termination shall be refunded and the Company shall have no further liability or responsibility under this Benefit Description.
6. When a Member is determined to be ineligible for coverage provided by the Underwriter of this Program. All rights of the Member may be terminated effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Member became ineligible for coverage. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded and the Company shall have no further liability or responsibility under this Benefit Description.

B. Benefits When Your Eligibility Terminates. Coverage under this Benefit Description ends on the date the Member no longer meets the Underwriter of this Program's definition for eligibility, except for a Member who is receiving Inpatient Hospital services when that person's coverage terminates. In such case, benefits may be extended for that Member without premium payment for a period not more than 31 days following the termination date of the coverage.

This extension of benefits will be terminated upon the earlier of:

1. The completion of a 31 day period following termination of coverage; or
2. The date Hospital confinement ends.
3. The date replacement coverage takes effect in which case the terminating coverage will become secondary to the replacement coverage.
4. Benefits of this section B.1. and B.2. are subject to the Deductible and Coinsurance and maximum benefit limitations applicable to the Member's coverage.

C. Certificate of Creditable Coverage. You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are a Member and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage contact the customer service center phone number on your Identification Card.

PART VIII

CONTINUED GROUP BENEFITS AND CONVERSION

A. Federal Law

There is a federal law which permits persons to continue coverage under an employer group health plan. This law is referred to as COBRA which stands for "The Consolidated Omnibus Budget Reconciliation Act of 1986" and any amendments thereto. That law applies to employers of 20 or more employees and such employer's group health plans, not to insurance contractors. That is, if Your employer changes from Blue Cross and Blue Shield of Kansas to another insurance carrier or third party administrator (in the case of self-funded arrangement), the right to continuation under federal law is a right which transfers to the new carrier or to claims adjudication under the new administrator.

This Section shall apply to the group and its Members only if the group is subject to the requirements of Title X of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any amendments thereto.

For more detailed information concerning COBRA, the Member should contact the Underwriter of this Program.

B. USERRA Continuation Coverage - Federal Law

1. If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
2. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing conditions exclusions) except for service connected illnesses or injuries.

For more detailed information concerning COBRA, the Subscriber or Member should contract the Group.

C. Conversion Privilege

1. A conversion privilege is available to the following persons:
   a. Those who have completed the period of Continued Group Benefits provided for in Section A above if Blue Cross and Blue Shield of Kansas is the insurer or administrator of that employer group health plan at the termination of COBRA continuation.
   b. Those who during the period of Continued Group Benefits provided for in Section A above choose to change to the Conversion Contract and so notify the Company. (So doing forever forfeits any right to further Continued Group Benefits under Section A above.)
   c. Those who at the time of initial eligibility for Continued Group Benefits under Section A above choose to go directly at that time to the Conversion Contract. (So doing forever forfeits any right to Continued Group Benefits under Section A above.)
   d. Those who do not qualify for Continued Group Benefits under Section A above.
2. A conversion privilege is not applicable to the following persons if the benefits referred to in paragraph b. below for such person or benefits provided or available under the sources referred to in paragraphs c. and d. below for such person, together with the benefits provided by the converted policy, would result in over-insurance based on Company standards as filed with the Kansas Insurance Department:
   a. Those who are or could be covered by Medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded).
   b. Those who are covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or
   c. Those who are eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or
   d. Those who have or have available similar benefits pursuant to or in accordance with the requirements of any state or federal law.
   e. Those who have had their coverage terminated pursuant to items A.4., 5. or 6, of the Termination of Eligibility Section.
3. Conversion Notice

   The Company will mail a conversion notice (including programs available and premiums) to those persons specified in Section B.1. Within 31 days of receipt of the notice, the person has the right to apply for a conversion contract by remitting the required premiums. The first required premium payment will be for a period commencing with the day following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Persons who are enrolled in Continued Group Benefits will be mailed the conversion notice prior to the end of the period for continued group benefits.

   a. Notice to the Member named on the Identification Card: The notice will be mailed to the Member's latest address as it appears on the records of the Company.
   b. Notice to dependents who cease to be eligible: The notice will be mailed to the dependent at the address provided the Company when the Company is notified that such person is no longer an eligible dependent.
4. The conversion contract does not require evidence of insurability of the person to be covered.
5. Persons residing outside the State of Kansas who, but for that fact, might otherwise be eligible for the Conversion Privilege set forth in item B above, will be eligible for a conversion contract from the Blue Cross and Blue Shield Company operating in the state in which such person resides.

PART IX

GENERAL INFORMATION

A. Member/Provider Relationship. The choice of a provider is solely the Member's. The use or non-use of an adjective such as Contracting or Non-Contracting in modifying any provider is not a statement as to the ability of the provider.

B. Your Identification Card. You must tell Your Institutional Provider or Professional Provider that You are eligible for Covered Services. When You receive services, show Your Identification Card at the provider's office. Show only the current card.

C. The Underwriter of this Program's Responsibility is Limited. Institutional Provider services are subject to the rules and regulations of the provider. This includes rules about admissions, discharge, and availability of services. The Underwriter of this Program does not guarantee that admission or that any specific type of room or kind of service will be available.

The Underwriter of this Program is obligated to provide benefits for the services of Your Professional Provider only to the extent provided in this Benefit Description. The Underwriter of this Program does not guarantee the availability of a provider.

The Underwriter of this Program will not be liable for any acts or wrongs of a provider of service. This includes negligence, misconduct, malpractice, refusal to give service, and breach of contract because of anything done or not done by a provider.

D. Your Authorization. By accepting coverage under this Benefit Description, You permit the Company to request any information related to a claim for services that You received and authorize that any information may be given to the Company regarding medical services You have received. This applies to all types of claims, including claims related to Medicare.

If the Company asks for information and does not receive it, payment for covered services cannot be made. The claim will be processed for payment only when the requested information has been received and reviewed.

E. Prompt Filing of Claims/Proof of Loss. Notice of Your claim must be given to the Company within 90 days after You receive services.

You are responsible for making sure Your Contracting Provider knows You are eligible for Covered Services and submits a claim for You.

If Your Non-Contracting Provider does not submit a claim for You, You must do so Yourself. If You need help submitting a claim, call or write the home office.

If it is not reasonably possible for You to submit a claim within 90 days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and 90 days after You receive services.

F. Time of Payment of Claims. Benefits payable under this Benefit Description will be paid immediately upon receipt of proper written proof of loss.

G. Request for Additional Information.

There may be occasions when additional information is needed in order to process Your claim. You have 90 days from the date this information is requested to furnish this additional information. If the additional information is not received by the Company within 90 days following the request, the claim will be denied.

H. Adjustment of Claims. No claim will be adjusted if the request is not received within 180 days of the completion of processing of that claim.

I. Legal Actions. No legal action may be brought to recover on this Benefit Description within 90 days after written proof of loss has been given as required by this Benefit Description. No such action may be brought after two (2) years from the time written proof of loss is required to be given.

J. Errors Related to Your Coverage. The Underwriter of this Program has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the Underwriter of this Program. The Underwriter of this Program has the responsibility to make additional payments if an underpayment has been made.

K. Notice.

From the Company to a Member.

A notice sent to a Member by the Company is considered "given" when mailed to the Member at his address as it appears on the records of the Company.

L. Notification of Change. The Members will be given notice of any approved benefit change by a rider, amendment, or any other proper written means. If major changes to the Benefit Description are made, new Benefit Descriptions or riders or amendments will also be issued.

M. Claims Procedures

1. **Purpose.** This section outlines the procedures for and the time periods applicable to Claim decisions and Appeal decisions for Urgent Claims, Pre-Service Claims and Post-Service Claims. It is the policy of the Company to afford Members a full and fair review of Claim decisions and Appeal decisions as described in this Benefit Description.
2. **Definitions.** For the purpose of this Claims Procedures Section, the following terms and their definitions apply:
   a. **Adverse Decision,** for the purposes of contractual Appeal procedures, means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which You are financially responsible or, for a Pre-Service Claim, for which You would be financially responsible, if You obtained the service.

service. Adverse Decision, for the purposes of External Review procedures, is limited to the definition of Adverse Decision Eligible for External Review.

   b. **Adverse Decision Eligible for External Review** means (1) in the case of other than a Medical Emergency, a Claim for a proposed or delivered health care service which would otherwise be covered under this Contract but for which the Insured has received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial leaves the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (2) in the case of a Medical Emergency, a Claim for which an initial Adverse Decision by the Company that a proposed health care service which would otherwise be covered under this Contract is not Medically Necessary or the health care treatment has been determined by the

Company to be Experimental or Investigational and the denial would leave the Insured with a financial obligation or prevents the Insured from receiving the requested service. Notwithstanding any provision of this Contract to the contrary, the External Review procedure is not available for dental services, or (3) a Pre-Service Request for a benefit determination or advance approval a) that is not a Pre-Service Claim; b) which is denied by the Company due to the fact the requested services are not Medically Necessary or are Experimental or Investigational; and c) based upon which You choose not to obtain the requested services. For item (3) above no Appeals need be submitted to the Company in order for the Adverse Decision to be eligible for External Review. For items (1) and (2) above, the information in items 4. and 5. below applies.

c. **Appeal** means a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to the Company by a Member or the Member's Authorized Representative.

d. **Authorized Representative** means, for non-urgent care, a person You designate in writing filed with the Company as authorized to pursue an Appeal on Your behalf. For Urgent Care, such written authorization is not required if the Appeal is made on Your behalf by a health care provider with knowledge of Your medical condition.

e. **Claim for Benefits or Claim** means a request for treatment benefit or payment benefits made by a Member in accordance with the Company's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Benefit Description.

f. **External Review** means the review of an Adverse Decision by an External Review Organization.

g. **External Review Organization** means an entity that conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.

h. **Pre-Service Claim** means a request for a Claims decision when prior authorization of the services is required by the Company.

i. **Pre-Service Request** means a request for advance information on the Company's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.

j. **Post-Service Claim** means a request for a Claims decision for services that have been provided.

k. **Urgent Care** means care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or, in the opinion of a physician knowledgeable of the Member's condition, would subject the Member to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, the Company must apply the judgement of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Member's medical condition determines that a Claim involves Urgent Care, the Claim must be treated as an Urgent Care Claim.

3. **Initial Claim Decisions**

The time periods in which the Company must make initial Claim decisions (the first determination of benefits available for a Pre-Service Claim or a Post-Service Claim) are as follows:

Action	**Urgent Claim**	**Pre-Service Claim**	**Post-Service Claim**
Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Initial Benefit Decision (from the date the Claim is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Claim is received by the Company)	None – Notice requesting additional information due – 24 hours*	30 days*	45 days*
* A Member may voluntarily agree to provide the Company additional time within which to make a decision.			
Time for Member to provide more information (from the date the information was requested by the Company)	48 hours	45 days	45 days

4. **Appeal of Initial Adverse Decisions (first level Appeal)**

A Member or the Member's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from an initial Claim decision. This is a first level Appeal.

a. The time periods that apply to first level Appeal decisions are as follows:

Action	Urgent Claim	Pre-Service Claim	Post-Service Claim
Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Time to file Appeal (from the date the Company made the initial Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Appeal is received by the Company)	None*	None*	None*
* A Member may voluntarily agree to provide the Company additional time within which to make a decision.			

b. A first level Appeal will be coordinated by a representative of the Company's Customer Service Center. If the Member wishes an additional review of the Claim, a second level Appeal can be requested.

5. **Second level Appeal relating to an Adverse Decision that is not an Adverse Decision Eligible for External Review**

A Member or the Member's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from a first level Appeal. This is a second level Appeal.

a. The time periods that apply to second level Appeal decisions are as follows:

Action	Urgent Claim	Pre-Service Claim	Post-Service Claim
Action	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Time to file Appeal (from the date the Company made the initial Adverse Decision)	180 days	180 days	180 days
Time to file Appeal (from the date the Company made the first level Appeal Adverse Decision)	90 days	90 days	90 days
Initial Appeal Decision (from the date the Appeal is received by the Company)	72 hours	15 days	30 days
Initial Appeal Decision (from the date the second level Appeal is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Appeal is received by the Company)	None*	None*	None*
Extension (from the date the second level Appeal is received by the Company)	None*	None*	None*
* A Member may voluntarily agree to provide the Company additional time within which to make a decision.			

b. A second level Appeal will be coordinated by a representative of the Company's Customer Service Center and the determination made by a person not subordinate to the first review.

6. **Second level Appeal relating to an Adverse Decision that is an Adverse Decision Eligible for External Review.**

a. **Waiver of second level Appeal.** If an Insured wishes to waive their right to a second level Appeal and proceed to the External Review, they may do so by sending written notice to the Company. This waiver will serve to exhaust all of the available internal appeals or review procedures for the Claim being reviewed.

b. **Second level Appeal**. If an Insured chooses not to waive their right to a second level Appeal, the Insured will have the right to appear in person before a designated representative or representatives of the Company. At least one of those designated representatives who will be deciding the second level Appeal shall be a physician and shall be present in person, by telephone or by other electronic means. The Insured has a right to:

(1) Receive from the Company upon, request, copies of all documents, records and other information that are not confidential or privileged relevant to the Insured's request for benefits;

(2) have a reasonable and adequate amount of time to present the Insured's case to a designated representative or representatives of the Company who will be deciding the second level Appeal;

(3) submit written comments, documents, records and other material relating to the request for benefits for the second level Appeal for the Company to consider when conducting the second level Appeal both before and, if applicable, at the second level Appeal meeting;

(4) prior to or during the second level Appeal ask questions relevant to the subject matter of any representative of the Company that is participating in the second level Appeal provided that such representative may respond verbally if the question is asked in person during an Insured's appearance in conjunction with the second level Appeal or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

(5) be assisted or represented at the second level Appeal meeting by an individual or individuals of the Insured's choice; and

(6) record the proceedings of the second level Appeal meeting at the expense of the Insured.

c. An Insured, or the Insured's Authorized Representative, wishing to request to appear in person in conjunction with the second level Appeal shall make the request to the Company within five working days before the date of the scheduled second level Appeal meeting except that in the case of an emergency medical condition, such request must be made no less than 24 hours prior to the scheduled second level Appeal meeting.

d. The Company shall provide the Insured a written decision setting forth the relevant facts and conclusions supporting its decision within:

(1) Seventy-two hours if the second level Appeal involves an Urgent Care Claim

(2) fifteen business days if the second level Appeal involves a Pre-Service Claim, and

(3) thirty days if the second level Appeal involves a Post-Service Claim.

7. **Procedure for Pursuing an External Review**

a. The Member has the right to request an External Review of an Adverse Decision Eligible for External Review after a second level Appeal (where applicable) has been completed or when the Member has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Member. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving a Medical Emergency, such request may be made before the Member has exhausted all the other available review procedures. The Company will notify the Member in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

b. Within 90 days of receipt of the notice of a final Adverse Decision, the Member, the treating physician or health care provider acting on behalf of the Member with written authorization from the Member, or a legally authorized designee of the Member must make a written request for an External Review to the Kansas Insurance Commissioner.

c. Within 10 business days of receipt of such request (immediately, when the request for External Review involves a Medical Emergency), the Kansas Insurance Commissioner will notify the Member and other involved parties as to whether the request for External Review is granted.

d. For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Member and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 7 business days when the request for External Review involves a Medical Emergency. The standard of review shall be whether the health care service denied by the Company was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Company was covered or excluded from coverage under the terms of this Benefit Description.

The right to External Review shall not be construed to change the terms of coverage under this Benefit Description. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

8. **Right to a Judicial Review**

After You have pursued the first and second level review of an Adverse Decision You have the right to sue in state court. In all events, such suit or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

O. Claims Recoveries.

There may be circumstances in which the Company recovers amounts paid as claims expense from the provider of service, from the Member or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for

certain specified pharmaceuticals, amounts recovered by the Company from health care providers or pharmaceutical manufactures through certain legal actions instituted by the Company relating to the claims expense of more than one Member, recoveries by the Company of overpayments made to health care providers or to Members, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following Company's actions with respect to such recoveries:

1. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Member and the Underwriter of this Program (subject to the limitations otherwise set forth below) shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Deductible and Coinsurances from a Member will be adjusted if affected by the recovery.
2. If such recovery amounts to less than $500 attributable in any Benefit Period (the period of time in which the Deductible or Coinsurance is calculated) for any Member, no adjustments in Deductibles or Coinsurances will be made, and the Underwriter of this Program (subject to the limitations otherwise set forth herein) shall be entitled to retain such recoveries for its own use.
3. If a Member is no longer covered by this program at the time any such recovery is made, the Underwriter of this Program (subject to limitations otherwise set forth herein) shall be entitled to retain such recovery for its own use.
4. In the event Blue Cross and Blue Shield of Kansas receives from pharmaceutical manufacturers rebates based upon amounts of claims paid by Blue Cross and Blue Shield of Kansas for certain specified pharmaceuticals, Blue Cross and Blue Shield of Kansas shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid on behalf of the Underwriter of this Program, to Deductibles or to Coinsurances paid by Members, or to other cost-sharing or claims amounts.
5. If the Underwriter of this Program no longer contracts with Blue Cross and Blue Shield at the time the recovery occurs, recoveries otherwise owing to the Underwriter of this Program pursuant to these rules will be paid to the Underwriter of this Program if fewer than five years have elapsed from the date of such recovery. Nothing, however, obligates Blue Cross and Blue Shield of Kansas to continue to pursue subrogation or other recoveries after termination of the Agreement, and such active subrogation files as Blue Cross and Blue Shield of Kansas maintains shall be returned to the Underwriter of this Program upon such termination.
6. Blue Cross and Blue Shield of Kansas has no obligation to pursue recovery from health care providers or manufacturers of health care products or services on behalf of the Underwriter of this Program for causes of action arising out of violations of antitrust law, fraud, claims relating to fraud (including claims under the Racketeering Influenced and Corrupt Organizations Act), and its administration of subrogation provisions (if any) under the Underwriter of this Program's benefit plan shall be limited in such circumstances solely to cases in which Members have individually initiated a claim or cause of action. Notwithstanding the foregoing, if (a) Blue Cross and Blue Shield of Kansas asserts a claim or cause of action against a party (other than the Underwriter of this Program itself) arising out of antitrust violations or fraud by health care providers or manufacturers of health care products or services relating to claims paid by Blue Cross and Blue Shield of Kansas under insured contracts and (b) claims payment made by Blue Cross and Blue Shield of Kansas on behalf of the Underwriter of this Program and Members would have been equally affected under the circumstances of such claim or cause of action, then the Underwriter of this Program assigns to Blue Cross and Blue Shield of Kansas its rights under such claim or cause of action. If recoveries by Blue Cross and Blue Shield of Kansas in such a claim or cause of action are less than actual injury asserted by Blue Cross and Blue Shield of Kansas for itself and on behalf of the Underwriter of this Program and other similarly situated underwriters of programs, then Blue Cross and Blue Shield of Kansas shall pay to the Underwriter of this Program a prorated amount based upon claims costs under this program compared to claims costs of Blue Cross and Blue Shield of Kansas under its insured programs. No adjustments of Deductibles or Coinsurances will be made for Members in such circumstances. This assignment of a cause of action shall survive termination of this program.
7. The total amount of any recoveries which are available for adjustments to claim of or payments to the Underwriter of this Program or for adjustments to cost sharing of Members of the program of the Underwriter of this Program in the form of Deductibles or Coinsurances will be reduced by the cost to Blue Cross and Blue Shield of Kansas to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on contingency basis, and other costs.

P. For additional information regarding the benefits covered hereunder, call the customer service center phone number on Your Identification Card. Information You request about benefits will be furnished without charge. Additional information can also be found on the website.

Q. Certificate of Creditable Coverage. You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are a Member and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage contact the customer service center phone number on your Identification Card.